

Health, Welfare, Public Service

FILED MAR 27 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-011460

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3223

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in lb <u>2079</u>	d. STREET ADDRESS (If outside, give location) <u>4927 Theodore Ave</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES REUBEN CHASTEEN</u>			4. DATE OF DEATH Month Day Year <u>MARCH 18, 1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1903</u>		9. AGE (In years last birthday) <u>54</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	11. BIRTHPLACE (City and state or country) <u>Stoddard County Missouri.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Edgar Chasteen</u>		13b. MOTHER'S MAIDEN NAME <u>Adalaide Siffert</u>		14. NAME OF HUSBAND OR WIFE <u>Lola Chasteen (nee Wahl)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>494 05 3832</u>		17. INFORMANT Address <u>Mrs. Lola Chasteen 4927 Theodore Ave 15</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA OF RIGHT LUNG WITH WIDESPREAD METASTASES TO LEFT LUNG AND LIVER</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<u>1621</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>FEB. 7, 1958</u> to <u>MARCH 18, 1958</u> and last saw her alive on <u>MARCH 18, 1958</u> Death occurred at <u>5:40 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>C. Vermillion, M.D.</u>			22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>3/18/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal.</u>		23b. DATE <u>March 21 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Frieden's Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>					
24. FUNERAL DIRECTOR ADDRESS <u>Calvin F. Feutz Funeral Home, 4828 Natural Bridge Blvd St. Louis Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>MAR 19 1958</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Ralph E. Linders* .....

Licensed Embalmer No. *4275* .....

P. O. Address *St. Louis, Mo.* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.